

Financing and Delivering Health Care in Balkan Region

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Health Care in Bulgaria in the Transition Period

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Bulgaria is a small country area 111.000 square kilometares, situated in the heart of the Balkan peninsula of Eastern Europe.

At the end of 1990 the population of Bulgaria was 8.989.165, with a proportion of 49,3 per cent males and 50,7 per cent females 6.114.254 / 68,0 per cent / live in big cities and urban area, while 2.874.911 / 32,0 per cent / live in the countryside (Fig. 1).

There is a significant process of "demographic aging" taking place in Bulgaria, with a specific rate of people in advanced age / 60 years + / reaching a percentage of 19,2. Meanwhile the index of young and adolescent population marks a continued decline (Fig. 2). The demografic aging is more evident in rural area, where it's two times higher than in urban area and this unpleasant age structure in the countryside is due mainly to the continued migration of young people from the villages to the big cities.

The natural growth of the population followed a tendency of negative values during the past several years being - 0,4 ‰ in 1990 and -1,5 ‰ for 1991, thus reflecting a continued decrease in general birth rate and a slight increase in general mortality rate (Fig. 3). An unpleasant fact is the increase of infant mortality rate which is as high as 14,8 ‰ in 1990 and growing to 16,7 ‰ in 1991 (Fig. 4). The cause-specific mortality rates assign the following top leading causes of death: cardiovascular disease / incl. coronary heart disease and cerebrovasculare disease / - 61,5% of all deaths per 100.000 population; cancer -13,9%; injuries and poisoning - 5,1%. The morbidity rate of population according to registered cases of diseases in health establishments of general type reaches 1466,2 cases per 100.000 population in 1990. We can hardly associate the slight improvement of morbidity indices since 1988 due to some better management of health care. This is rather connected with a diminished number of patient visits in all kinds of health establishments. By classes of diseases there isn't a significant change for the last 10-15 years which is seen on Table 1.

Economic, social and political life in Bulgaria are in a period of profound democratic reform, which inevitably has it's influence on the health care system. The political stability, the micro and macroeconomic development on a regional level, as well as in the country as a whole determine the nature of changes in Bulgarian health care system.

Within the provision of the new Constitution from 1991 and under article 52 "All sitizens are guarantied with health insurance which gives access to medical care and medical services in order to the clauses of the legislation. Additional charges are taken for certain cosmetic services, ortodontures, abortion on demand and for part of the cost of drugs prescribes out of hospital 1991 was the year of releasing the private medical practice after it was prohibited by law in 1972. In a process of discussion by the legislation is a new health insurance system

which would provide the financial interface of public and private medical sectors and would allow the further development of health care reform in Bulgaria.

A synopsis of management and organisational principles and current discrepancies in Bulgarian health care system are given in Fig. 5:

Management and organisational principles

- high centralisation and dependency on the state
- development according to plan
- financial allocations from the state budget

Discrepancies

- ineffective management and expenditure of funds
- between unforeseen needs met by extrabudgetary subsidies
- between the market economy reform and the existing health care system
- between the potentials of biomedical science and technologies and level of utilization by health consumers.

When the health budget was drawn up general norms and limits were used which had been developed according to expenditures in the preceding years while little consideration was taken of the supply and demand of health services on district, regional and national level.

The centralized normative decision making resulted **in**:

- assigning medical services on a district level thus limiting the free choice of a physician
- unequal distribution of health care resources through and the different regions of the country and concentration of highly specialized manpower and technologies in big cities and urban area
- a phenomenon of hyperproduction of medical staff
- hyperhospitalization of primary health care services etc.

The health reform from 1990 adopted two important approaches (Fig. 6).

- decentralization of health care and expanding the democracy of decision making by active participation of the community at large in the development of the local health services
- equality of all forms of health care services while regularizing social safety for all strata of the society.

The main priorities for fulfilling those approaches have been as follows:

- designating general **norms** and limits differentiated according to types **of services** and activities
- establishing proportionality and stability in financing the health care system
- introducing a new type of health care management
- alteration of the parameters of the health care system as a whole.

The entire managerial activity of health care in Bulgaria includes three levels of functioning (Fig. 7).

The Ministry of Health concentrate its efforts on major national and regional goals according to the policy of the government. This is the so called "strategic" health care management which puts emphasis on the improvement of the material base for health care and makes optimum use of the existing human and financial resources for health. In particular, the Ministry of Health is responsible for:

- planning and coordinating programmes for health prevention and health promotion of the population
- as a government official contributes to the legislation of medical law
- designates norms and limits for work quality of medical and dental services
- ensures the rational use of all health resources by the application of economic approaches
- coordinates the health care activities on regional level by district and municipal councils.

Some times the authorization of the Ministry of Health is not clearly defined, so that there is overlap of rights and obligations with other government officials. Such are cases with the Ministry of Environment regarding problems of ecology; with the Ministry of Social welfare regarding problems of invalidization etc.

The middle level of health management is municipal, providing local health care and services through district and municipal Council. The continuous changes in the community structure, the new administrative division of the country caused a loss in the representativeness of self-government in municipal organs. Following the health reform in the community a tendency of economic, administrative and informational renovation is registered. The point is more professionalism in training and retraining of manpower in accordance with the demands of organization and the system of health care management.

The third level of management is on the line of health establishments / operational management /. Article N.118 from 10.06.9 reads that the management of health establishments is carried out by general manager, medical director and head nurse / or midwife / appointed by the Board of Directors. The latter is elected as a body of commissioners, representing the medical and nonmedical state of the health establishment.

The priorities of this new management approach are:

- principle of electivity
- authorization by a mandate commission
- pluralism and joint responsibility
- competitive election
- differentiating medical from financial activities etc.

The application of the system outlined some contradictory interrelation such as unclearly defined subordination between general manager, medical director, head nurse and Board of Directors which actually complicates the process of decision making.

As the health reform gained speed some new institutions emerged with claims and abili-

ties to participate in the health management system. These are the re-established Bulgarian medical and dental association, trade-union organizations of medical workers etc. An important consideration is to delegate some of the duties of the Ministry of Health to these professional organizations, much more the initiation of the new health insurance system, with an executive body, health insurance funds etc. would direct the attention of any managerial staff at this "strategic" office.

The financial support of health care is provided for the present entirely by the state budget which is formed by taxes and fees on national and community level (Fig. 8). The allocations for health care were 6,1% from the national income in 1985, 7,4% in 1990 and 7,2% in 1991. Under the circumstances of economic crisis and high rate of inflation, which reached 600% in 1991, health expenditures come up with great difficulty to the standard requirements of supplies, consumatives and medicine. The health budget is shared out as follows:

- institutes and establishments of national importance which are directly subordinated to the Ministry of Health
- district and regional health service establishments **subordinated and financed by the** respective local authorities
- workers health service establishments which are financed both by the local authorities and by the industrial enterprise whose workers they serve.

The health budget is drawn up using financial norms and target figures on terms of agreement between the Ministry of Health and Ministry of Finance. The financial policy is granting funds on a piece of workmanship and the type of expenditures. The development of health insurance system is expected to ensure supplementary mechanisms for balance and control such as:

- introducing system for evaluation of health care activities
- reorganizing health establishments into corporations of legal entity
- foundation of contracting parties for health care services
- ranking medical establishments and differentiating positions within them so that payment correspond to adequate delegation.

So far the main dimensions of health reform include:

- effectiveness of the health management system
- definite priorities in delivering and financing health care services
- equality of public, private and insurance medicine while keeping up social safety for all strata.

Primary health care in Bulgaria is provided on outpatient basis by the polyclinic and the rural health service. Teamwork has been introduced increasingly into health care, each team composed of a variety of health workers: several general practitioners, pediatrician, a specialist in obstetrics and gynecology, a surgeon, a neurologist, an ear-nose-throat specialist, an ophthalmologist and a dermatologist. By coordinating their working hours the team provides diagnostic and therapeutic care of high quality. The territorial principle / residential or

occupational / of organization of primary health care makes it possible to integrate all medical and sanitary measures relating to the individual or to the environment. According to the number of population served and to the functions carried out, the following types of health districts are distinguished:

- rural health district: covers one or more villages with a total population of 1.500 to 2.500
- therapeutic district: the basis unit of outpatient care for the adult population; covers a population of 3.000 to 3.500
- factory health district: set up at enterprises employing 1.200 to 2000 workers
- paediatric district: covers a population of about 1.000 children up to 15 years of age
- school health district: set up at any educational institution with 2.000 or more students
- OG district: covers an area with a population of 17.000 to 18.000 or an industrial enterprise employing at least 4.000 workers

Although resolving most of the health problems of the population primary health care / or frontline health care / still has its disadvantages:

- financial duplicity of health districts: funds are provided by the local authorities but are under the general control of the rural health service or polyclinic.
- unequal distribution of health districts in the province
- impossibility of free choice of a physician because of the territorial principle
- unequipped of frontline health care with up-to-date methods and technologies for diagnosis and treatment, thus constantly dispatching patients to higher levels
- inadequate material and financial incentives for medical staff working on the frontline
- inadequate qualification and management skills of provincial health managers
- ineffective system of postgraduate education, specializing inadequate number of GPs

The impatient diagnostic and therapeutic services are provided by several types of hospital establishments:

- general hospitals on a district and community level
- specialty hospitals and specialized dispensaries for chronically impaired patients
- university clinics and departments.

The average number of beds provided per 10.000 population has been continuously increasing and reaching 100 beds in 1990, which is better indicator compared with developed countries such as Denmark - 73,8%, Italy - 77,7%, Holland - 61,9%, Spain - 48,1%. The bed occupancy by types has changed its structure since 1980 resulting decrease of beds from 67,5% in 1980 to 64,8% in 1990 in health establishments of general type. This is partly because of dispatch of unmanaged patients from provincial health district to highly specialized hospital units which burdens additionally the health budget with cost expensive beds. The extensive bed structure development subsequently reduced the average occupancy rate

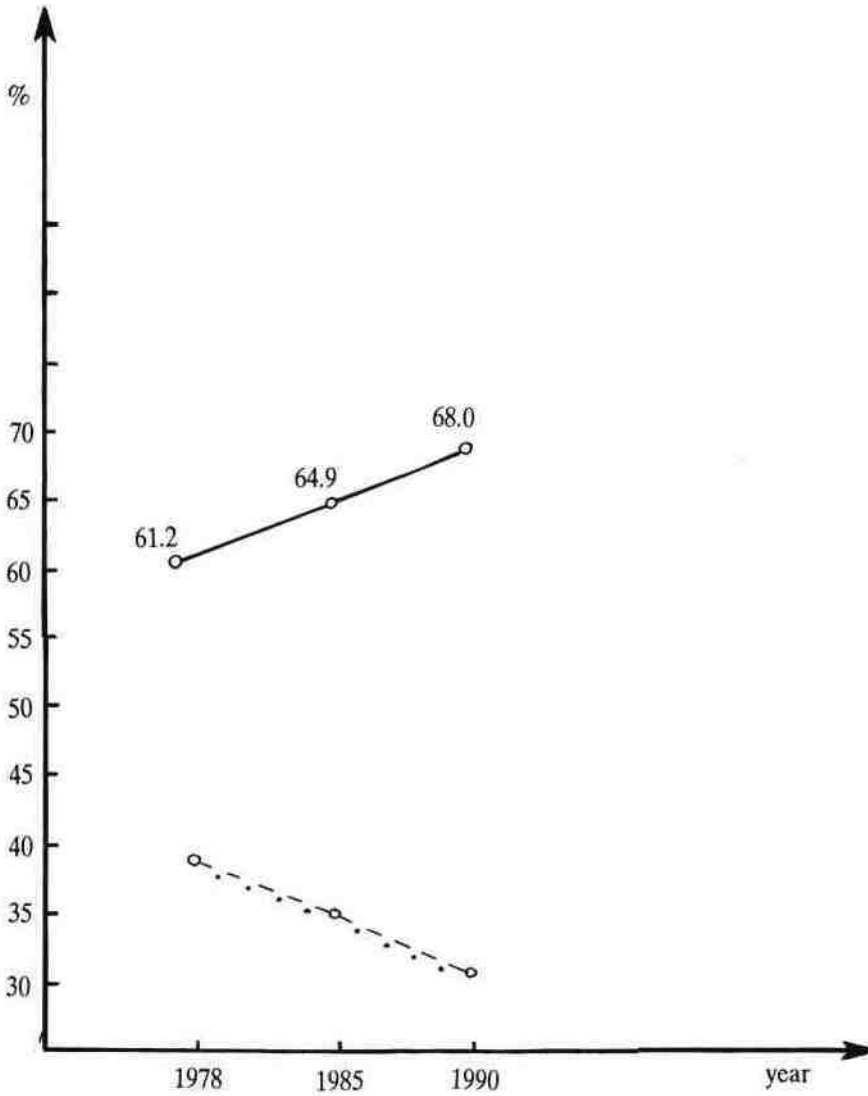
/ from 87,2% in 1980 to 77,0% in 1990 / and the average length of stay / from 15,2 days in 1980 to 13,7 days in 1990/ (Fig 9). Trends in hospital care consider several target alterations:

- comprehensive provision of norms and limits for quality and effective inpatient health care.
- remodelization of the existing hospital system and privatization of certain fields of inpatient care
- comprehensive definition of the structure, delegation, subordination and interrelation of all types of hospital care establishment
- development of a new type of an operational management.

A health reform without an adequate management approach is inconceivable. The essentials for an effective advance require the liquidation of the stereotypes of old management thinking, adopting professional attitude and style on every level of management activity. We still pay a high price for poor management decisions in the past such-as the prohibition of private medical practice, the ambition for a total dispensarization, the unbalanced productivity of medical manpower etc.

Today Bulgaria lives in the air of a timely management "boom". Commercialism, non-conceptual and unsystematic training, political ambition etc. gave birth of a whole army of pseudohcalth managers. A comprehensive identification with the economic, sociological, psychological, informational aspects of the theory and practice of management is necessary in the future. Much more the university graduate and postgraduate education included most of the elements of modern management science. The problem is elimination of totalitarian dogma, systematization of knowledge, qualification and requalification of professionals within national and international management education programmes.

Fig. 1. Population



Urban _____
Rural - - - - -

Fig. 2. Age Structure

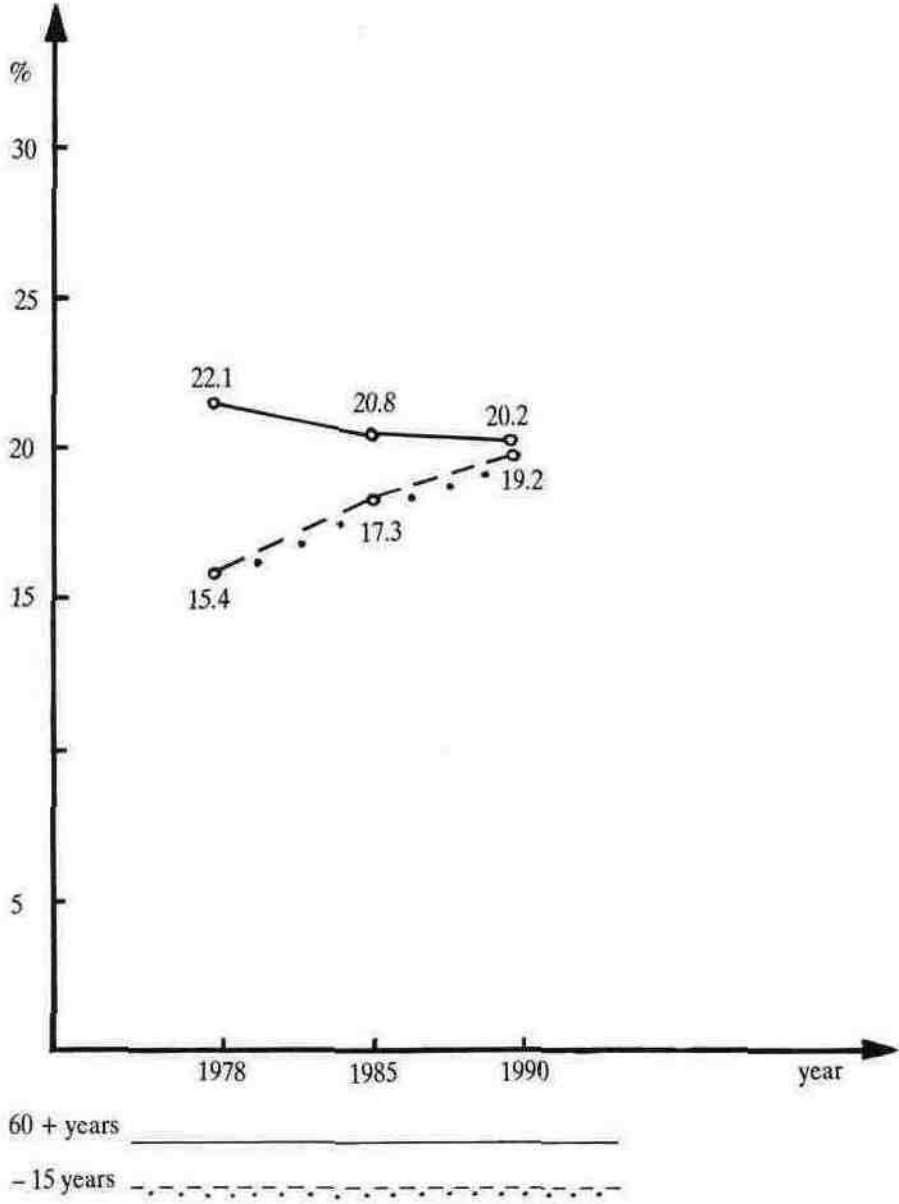


Fig. 3. Demographic Structure

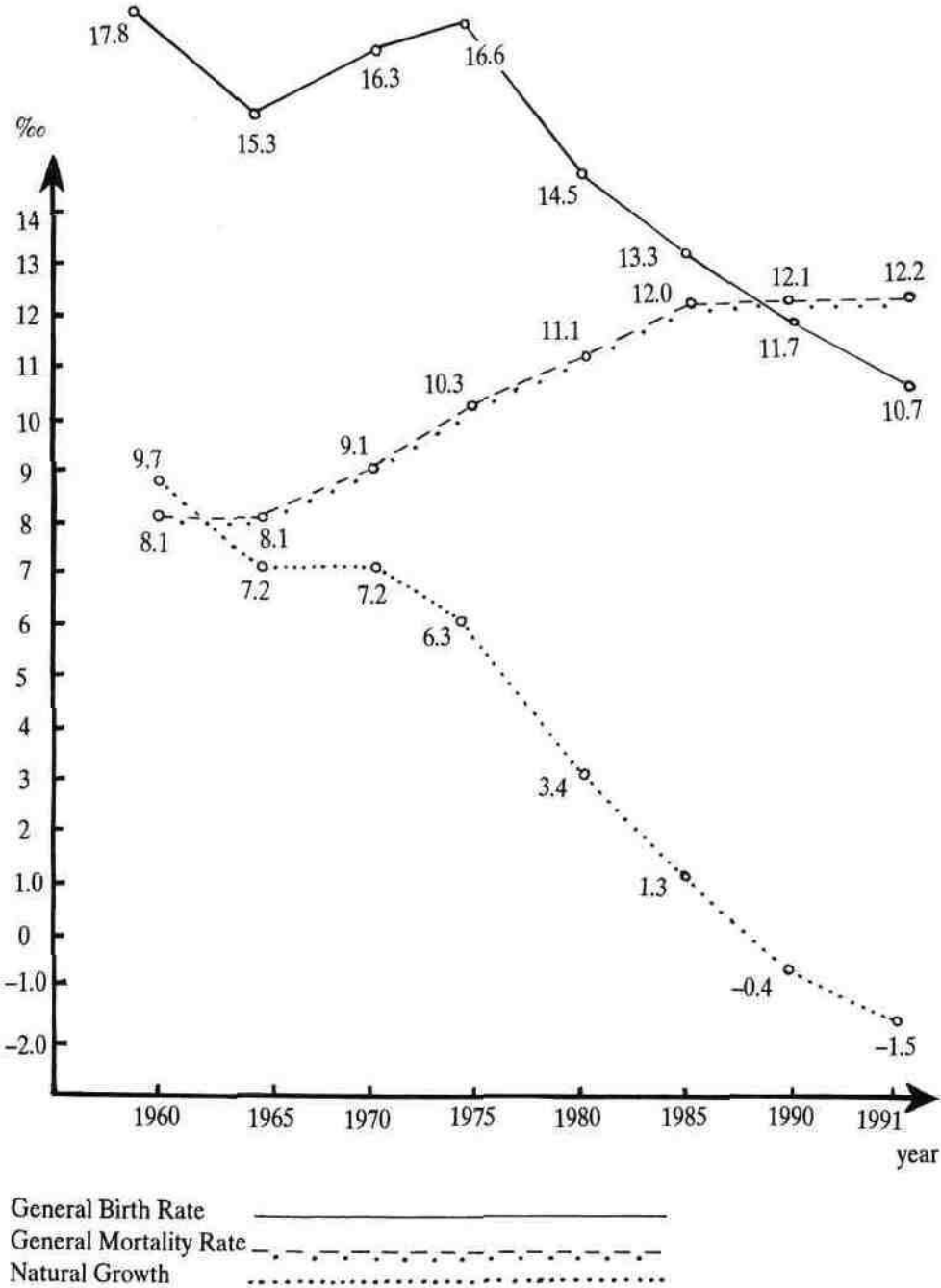


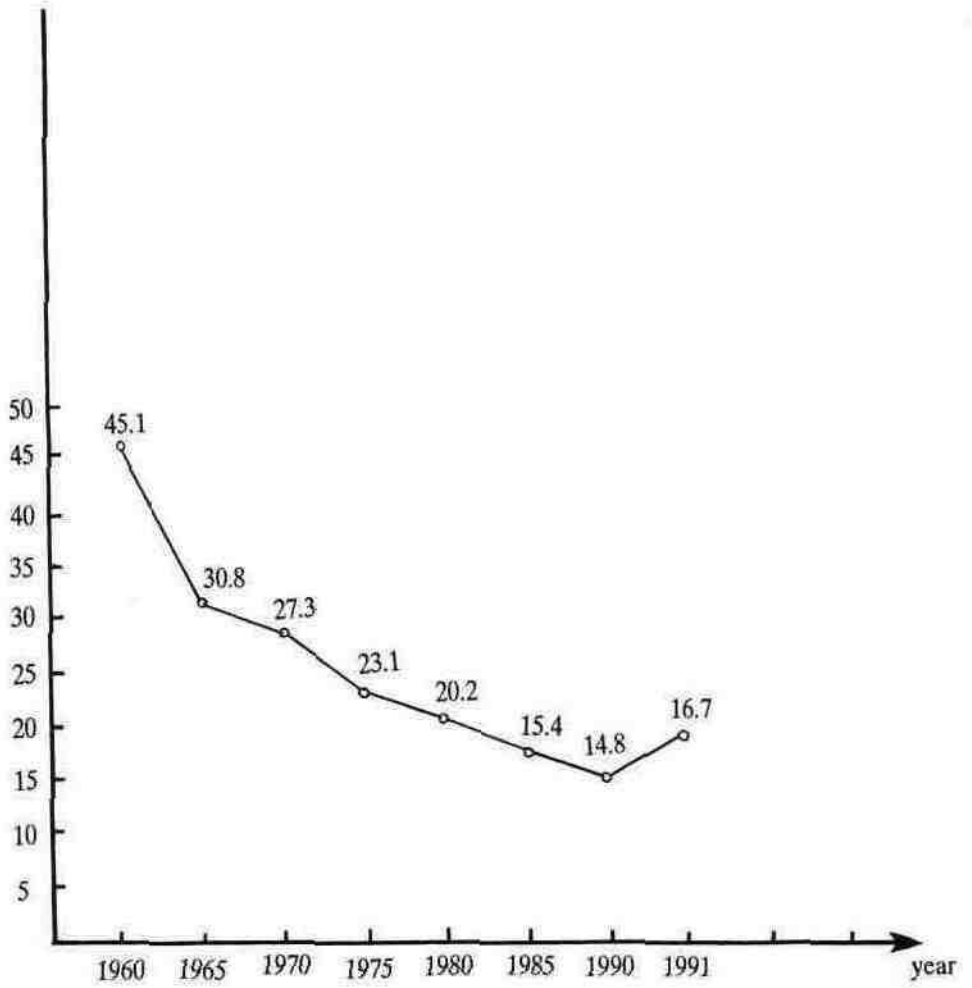
Fig. 4 Infant Mortality Rate in Bulgaria

Fig. 5.

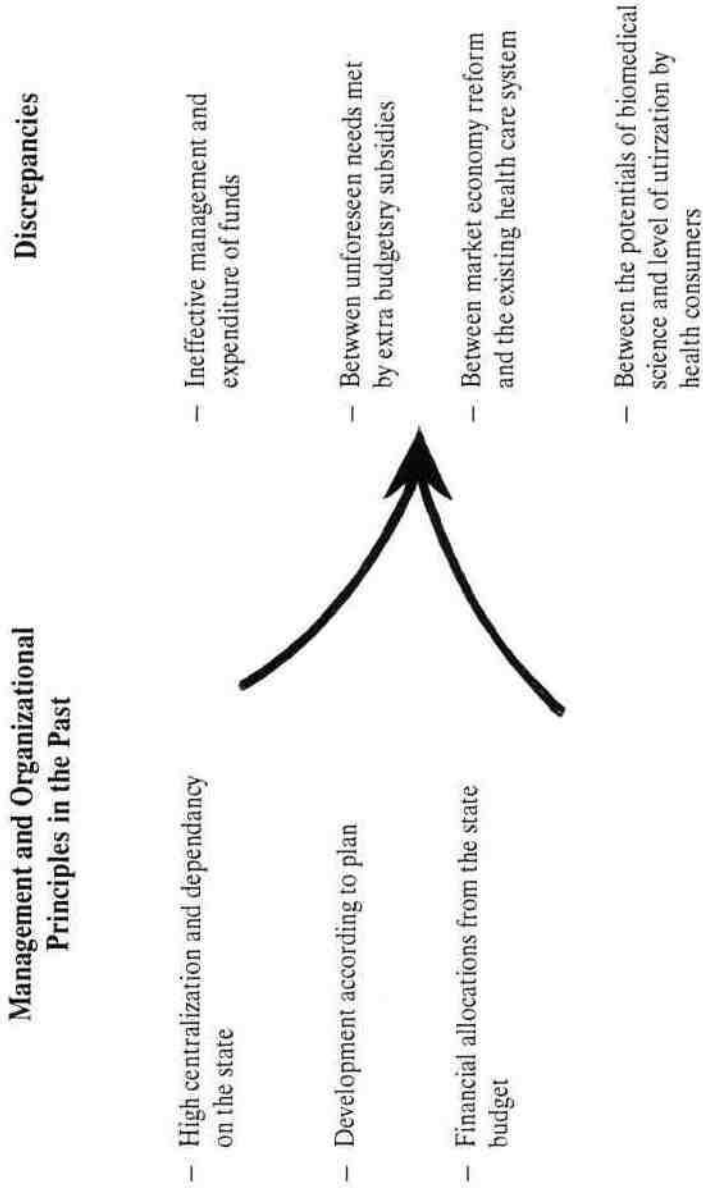


Fig. 6. Important Approaches in Health Reform

1. Decentralization of health care

2. Equality of public, private and insurance medicine

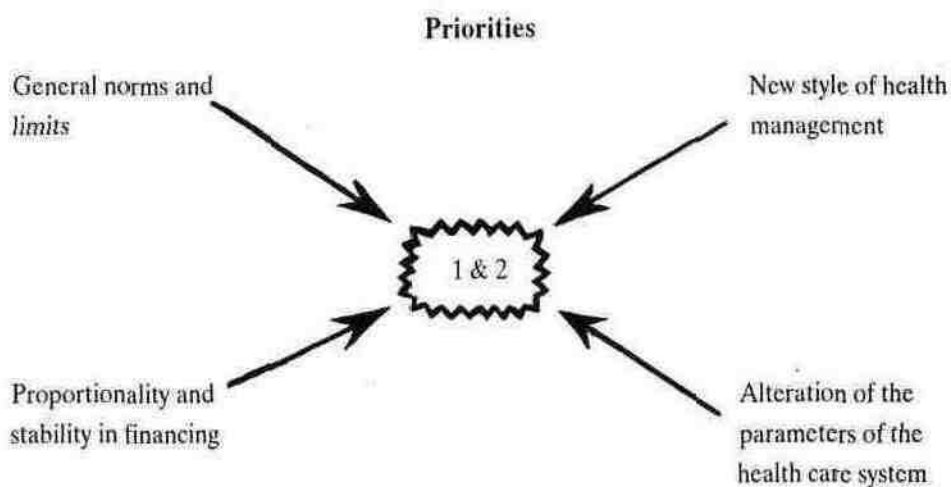


Fig. 7. Levels of Health Management Activity

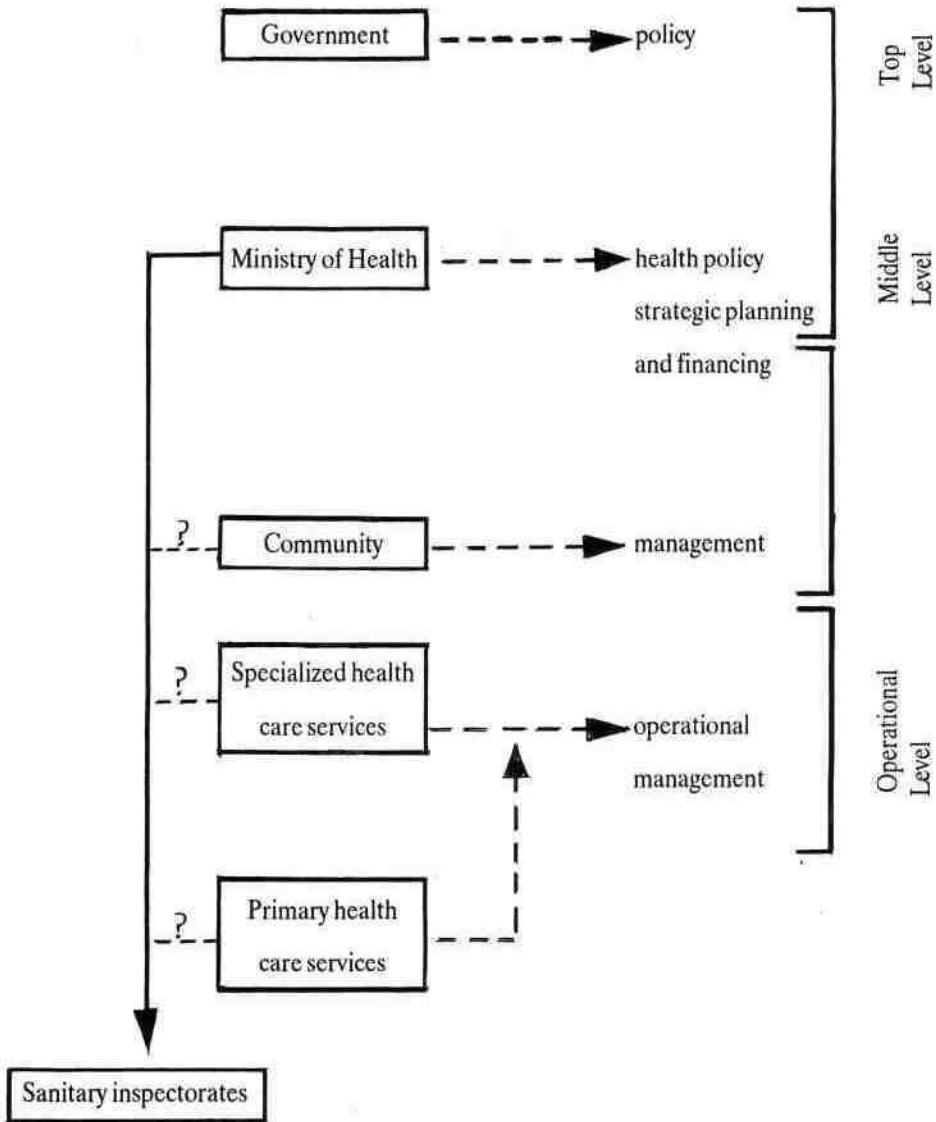


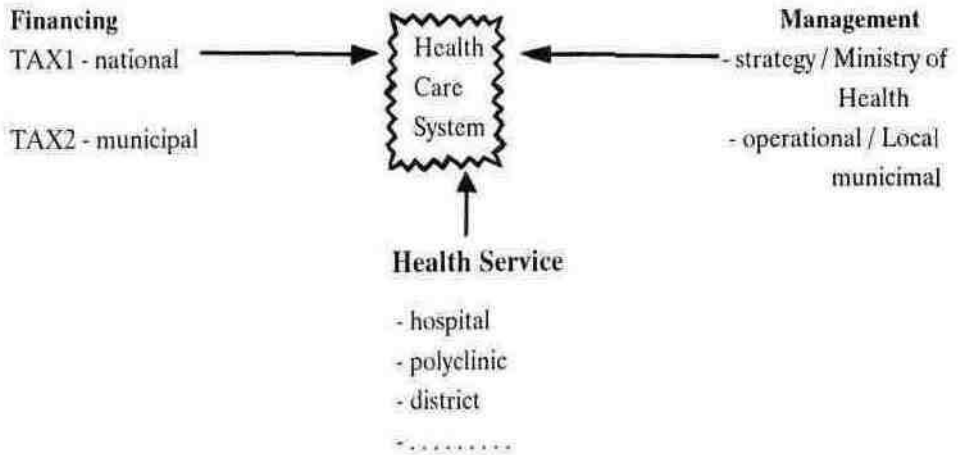
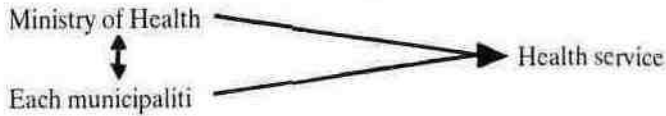
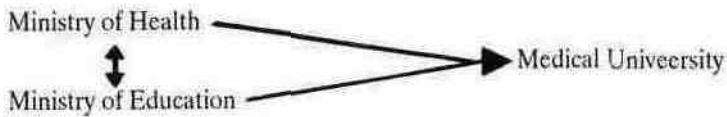
Fig. 8. Health Care Management and Financing**Investment Cost****Planning of Manpower**

Fig. 9. Bed Structure

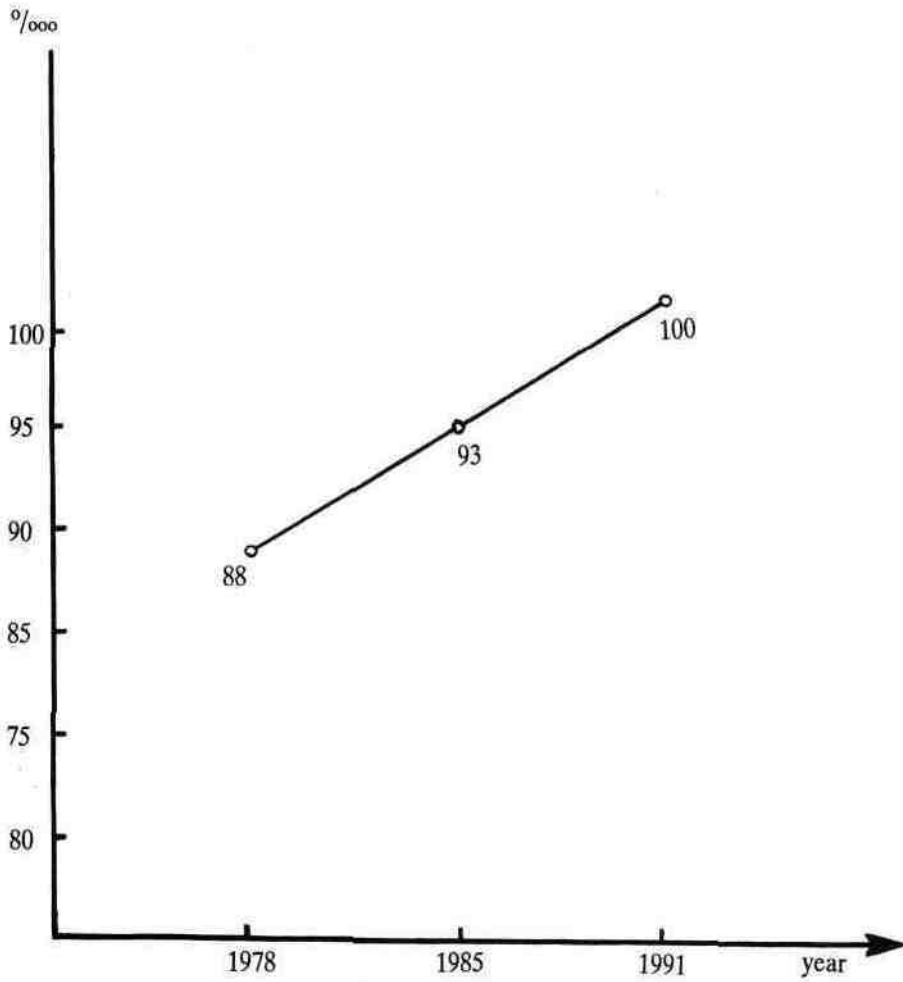


Table 1: Morbidity by Classes Of Diseases

Year	General morbidity / per 100.000 / population	Respiratory diseases / % /	Cardiovascular diseases / % /	Neurologic diseases / % /	Neoplasma / per 100.000 / population
1978	1062,7	41,0	8,4	11,3	225,9
1985	1683,8	44,7	6,7	12,4	223,0
1990	1466,2	43,7	6,5	12,8	1709,0

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